Whitecross Dental Care Limited

Mydentist - Bath Lane - Mansfield

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 22 November 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

The practice is located in a semi-detached property close to Mansfield town centre. The practice is located on two floors of premises with patient areas on both the first and ground floor. The practice provides mostly NHS dental treatments (95%). There is time limited car parking to the front of the practice or pay and display car parking in the town centre. There are four treatment rooms two of which are located on the ground floor.

The practice provides regulated dental services to both adults and children. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are – Monday to Wednesday: 8:30 am to 6 pm; Thursday: 8:30 am to 5 pm; Friday: 8:30 am to 4 pm. The practice is closed at the weekend.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Alternatively patients could telephone the NHS 111 telephone number.

The practice manager is the registered manager. A registered manager is a person who is registered with the

Summary of findings

Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice is registered with the Care Quality Commission (CQC) as an organisation.

The practice has four dentists (one is a locum dentist); one dental hygienist/ therapist; one qualified dental nurse; two trainee nurses; one receptionist and one practice manager.

Before the inspection we sent CQC comments cards to the practice for patients to tell us about their experience of the practice. We also spoke with patients during the inspection to gather their views of the practice. We received feedback from 16 patients who provided a positive view of the services the practice provides.

Our key findings were:

- The premises were visibly clean and there were systems and processes in place to maintain the cleanliness.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Six monthly infection control audits had not been completed as recommended in the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05)
- Patients said they had no problem getting an appointment that suited their needs.
- Patients were able to access emergency treatment when they were in pain.
- Patients provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect; and the dentist involved them in discussions about treatment options and answered questions.
- Patients' confidentiality was protected.
- There were systems to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- The records showed that apologies had been given for any concerns or upset that patients had experienced at the practice.
- With the exception of regular audits the practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.

There were areas where the provider could make improvements and should:

- Review the practice's infection control procedures and protocols in relation to carrying out six monthly audits as identified in the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

We found that this practice was providing safe care in accordance with the relevant regulations.

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines and oxygen available, and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

Recruitment checks were completed on all new members of staff. This was to ensure staff were suitable and appropriately qualified and experienced to carry out their role.

The practice was visibly clean and had infection control procedures to ensure that patients were protected from potential risks. Infection control audits of the decontamination process were not as recommended by the current guidance.

X-ray equipment was regularly serviced to make sure it was safe for use.

Are services effective?

No action

We found that this practice was providing effective care in accordance with the relevant regulations.

All patients were clinically assessed by a dentist before any treatment began. The practice used a recognised assessment process to identify any potential areas of concern in a patient's mouth including their soft tissues (gums, cheeks and tongue).

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, lower wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

The practice had systems in place for making referrals to other dental professional when it was clinically necessary.

Are services caring?

No action

We found that this practice was providing caring services in accordance with the relevant regulations.

Patient confidentiality was maintained and electronic dental care records were password protected.

Feedback from patients identified staff were friendly, and treated patients with care and concern. Patients also said they were treated with dignity and respect.

There were systems for patients to be able to express their views and opinions.

Summary of findings

Are services responsive to people's needs?

No action

We found that this practice was providing responsive care in accordance with the relevant regulations.

Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

There were treatment rooms located on the ground floor which allowed easy access for patients with restricted mobility. However, the premises were not suitable for patients who used a wheelchair. Those patients could be seen at another practice in the group 150 yards away which was fully accessible to patients using a wheelchair.

An access statement in line with the Equality Act (2010) had been completed to consider the needs of patients with restricted mobility. The practice had an induction hearing loop to assist patients who used a hearing aid.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays.

There were systems and processes to support patients to make formal complaints. Where complaints had been made these were acted upon, and apologies given when necessary.

Are services well-led?

No action

We found that this practice was providing well-led care in accordance with the relevant regulations.

There was a clear management structure at the practice. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

The practice had a system for carrying out regular audits of both clinical and non-clinical areas to assess the safety and effectiveness of the services provided. These policies and procedures had been kept under review.

Patients were able to express their views and comments, and the practice listened to those views and acted upon them.

Staff said they were happy working at the practice, and they could speak with a senior colleague if they had any concerns.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, comprehensive inspection on 22 November 2016. The inspection team consisted of a Care Quality Commission (CQC) inspector and a dental specialist advisor.

Before the inspection we asked for information to be sent, this included the complaints the practice had received in the last 12 months; their latest statement of purpose; the details of the staff members, their qualifications and proof of registration with their professional bodies.

We reviewed policies, procedures and other documents. We received feedback from 16 patients about the dental service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems for recording and investigating accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. The practice had an accident reporting policy which was dated December 2015. There was an accident book however, this had no entries and the previous accident book had gone missing.

The practice had not required to make any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reports although staff said they were aware how to make these on-line.

Records at the practice showed there had been two significant events in the twelve months leading up to this inspection. The last recorded event had occurred in May 2016 and related to a break in at the practice overnight. This had been reported to the Care Quality Commission as a police incident, although the service was also disrupted due to damage caused during the break in. The records showed all significant events had been analysed and discussed with staff as appropriate.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. These were received by the provider and analysed and circulated to staff as appropriate. The most recent alert had been received in June 2016 and related to a medicine safety alert.

Discussions with a senior manager and review of e mail correspondence identified that patients were told when they are affected by something that went wrong, given an apology and informed of any actions taken as a result. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Discussions with the practice manager identified they knew when and how to notify CQC of incidents which caused harm.

Reliable safety systems and processes (including safeguarding)

The practice had a policy for safeguarding vulnerable adults and children which was dated May 2015 and was due for review. The policy identified how to respond to and escalate any safeguarding concerns. The different types of abuse were identified and the relevant contact telephone numbers and a flow chart were available for staff both within the policy and on the staff room notice board. A copy of the General Dental Council (GDC) 'Guidance on child protection and vulnerable adults' dated September 2013 was also available in the practice for staff. Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary. The practice manager said there had been no safeguarding referrals made by the practice.

The practice manager was the identified lead for safeguarding in the practice. They had received training in safeguarding adults and children to level two in November 2016 which was valid for three years to support them in fulfilling that role. We saw evidence that all staff had completed safeguarding training to level two during 2016.

The practice had a procedure for staff regarding the Control Of Substances Hazardous to Health (COSHH) Regulations 2002 this was dated December 2015. The procedure identified the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. There were hard copies of manufacturers' product data sheets which were kept centrally and were accessible to all staff. Data sheets provided information on how to deal will spillages or accidental contact with chemicals and advised what protective clothing to wear.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 1 April 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a copy of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw the practice used a recognised system for handling sharps safely in accordance with the Regulations and practice policy. Practice policy was that only dentists handled sharp instruments. We saw there were devices in each clinical area for the safe removal and disposal of needles and sharps.

Are services safe?

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bins were wall mounted in clinical areas which followed the guidance which indicated sharps bins should not be located on the floor, and should be out of reach of small children. Sharps bins were signed and dated. The National Institute for Healthcare Excellence (NICE) guidelines: 'Healthcare-associated infections: prevention and control in primary and community care' advise – sharps boxes should be replaced every three months even if not full. Signing and dating allowed the three month expiry date to be identified.

Discussions with dentists identified they were using rubber dams when providing root canal treatment to patients. Guidance from the British Endodontic Society is that rubber dams should be used whenever possible. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment (treatment involving the root canal of the tooth) is being provided. On the rare occasions when it is not possible to use rubber dam the reasons should be recorded in the patient's dental care records giving details as to how the patient's safety was assured. We saw the practice had a supply of rubber dam kits in the practice. A leaflet for patients in the waiting rooms explained what root canal treatments were and when they were used.

Medical emergencies

The dental practice had a medical emergency policy which was due to be reviewed in January 2017. The practice equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and found they were all in date. There were systems in place to check expiry dates and monitor that equipment was safe and working correctly. The practice had a second emergency kit which was used as a back-up.

There was a first aid box which was located centrally. We saw evidence the contents were being checked regularly. We saw certificates demonstrating three members of staff had completed a first aid at work course and that the training was still in date.

There was an automated external defibrillator (AED) at the practice. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The AED was being checked regularly to ensure it was working correctly. This complied with the Resuscitation Council UK guidelines.

All staff at the practice had completed basic life support and resuscitation training on 9 December 2015.

Additional emergency equipment available at the practice included: airways to support breathing, a bag valve mask for manual resuscitation, oxygen masks for adults and children and portable suction.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies.

Staff recruitment

We looked at the staff recruitment files for eight staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the person's skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that all staff had received a DBS check. We discussed the records that should be held in the recruitment files with the practice manager.

Monitoring health & safety and responding to risks

The practice had a health and safety risk assessment completed by an external company in July 2011. This had been reviewed during 2016.

There were various policies relating to different aspects of health and safety such as manual handling and accident reporting. These were identified in the practice health and safety handbook for staff. The policy identified the practice

manager as the lead person who had responsibility within the practice for different areas of health and safety. As part of this policy environmental risk assessments had been completed. For example there were risk assessments for: fire, sharps and manual handling.

Records showed that fire extinguishers had been serviced in July 2016. The practice had a fire risk assessment which was dated 18 July 2011 and had been reviewed in November 2016. The risk assessment identified the practice as being a medium risk for fire safety. The risk assessment identified the steps to take to reduce the risk of fire. We saw there was an automatic fire detection system and emergency lighting installed within the premises. Records showed the practice held a fire evacuation drill every six months with the last one completed on 6 September 2016.

The practice had a health and safety law poster on display in the staff room. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

A Business Continuity Plan was available in the practice and a copy was held off site. The plan had last been updated in October 2016. This identified the steps for staff to take should there be an event which threatened the continuity of the service such as a fire, flood or electrical failure.

Infection control

The practice had an infection control policy which had been reviewed in December 2015. This was available to staff in the policy file. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed that regular six monthly infection control audits had not been completed. The Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment recommends six monthly audits. The records showed audits had been completed annually with the last three completed on: 11 September 2014, 16 April 2015 and 28 October 2016. The practice manager said that going forward six monthly infection control audits would be completed. The latest audit had scored 96% and highlighted issues with regard to the decontamination room. There was an action plan in place and plans had been made to refurbish the decontamination room. The practice manager said this was planned to be completed by the end of April 2017.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. We noted that clinical waste bags were not marked with the practice details so there was no audit trail to track waste back to the practice. The practice manager said this would be dealt with and put measures in place during the inspection. The clinical waste contract also covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had spillage kits for mercury and bodily fluids. Both spillage kits were within their use by date.

There was one decontamination room where dental instruments were cleaned and sterilised and then bagged, date stamped and stored. This room was due to be refurbished in the weeks following this inspection. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear. The practice was latex free to avoid any risk to staff or patients who might have a latex allergy.

We saw that posters giving instruction on good hand washing technique were on display by hand washing sinks throughout the practice. Liquid soap and paper towels were also available. The practice had a hand hygiene policy for staff which was due for review in December 2016. The policy gave staff clear instructions on how to reduce the risk of cross infection through good hand washing techniques. However we saw no evidence of any hand washing audits at the practice.

A dental nurse demonstrated the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05).

The practice had a washer disinfector, a machine for cleaning dental instruments similar to a domestic dish washer. As a backup the practice had the necessary equipment for manual cleaning including a long handled brush, heavy duty gloves and a digital thermometer as identified in the guidance (HTM 01-05). After cleaning instruments were rinsed and examined using an

illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's autoclaves (a device for sterilising dental and medical instruments). The practice had two autoclaves. At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were records to demonstrate this and that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

The practice had a policy for dealing with blood borne viruses. There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The risks associated with Legionella had been assessed. This process had been completed by an external contractor and had been reviewed by them in August 2016. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice had taken steps to reduce the risks associated with Legionella with regular flushing of dental water lines as identified in the relevant guidance.

Equipment and medicines

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice in September 2016. There was an electrical installation condition report dated 6 June 2016 which had assessed the condition of the electric installation at the practice. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in September 2016. This was in accordance with the Pressure Systems Safety Regulations (2000). Records showed the autoclaves had been serviced in July 2016.

The practice had all of the medicines needed for an emergency situation, as identified in the Guidance on Emergency Medicines set out in the 'British National Formulary' (BNF).

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Radiography (X-rays)

There was a Radiation Protection file which contained the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had four intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth).

X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The Radiation Protection file identified the practice had radiation protection supervisors (RPS) this being the dentists at the practice. The provider had appointed an external radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

The practice had critical examination documentation for three of the four X-ray machines. Critical examinations are completed when X-ray machines are installed to document they have been installed and are working correctly. The documentation for the fourth machine could not be located either at the practice or by the RPA. However, the fourth X-ray machine had been serviced in the recommended time frame and no problems had been identified. The practice manager said the RPA would be contacted to carry out another critical examination on this X-ray machine.

Records showed the X-ray equipment had been inspected in October 2016. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years. The regulations also required

Are services safe?

providers to inform the Health and Safety Executive (HSE) that X-rays were being carried out on the premises. Documentary evidence dated 2011 when the practice changed hands confirmed this had been completed.

The practice used digital X-rays, which allowed the image to be viewed almost immediately, and relied on lower doses of radiation. This therefore reduced the risks to both the patients and staff.

We saw that three intraoral X-ray machines were fitted with rectangular collimation in line with current guidance. Rectangular collimation is a specialised metal barrier attached to the head of the X-ray machine. The barrier has a hole in the middle used to reduce the size and shape of the X-ray beam, thereby reducing the amount of radiation the patient receives and the size of the area affected. The fourth X-ray machine was not being used until a new collimator had been fitted.

All patients were required to complete a medical history form and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant and nursing mothers.

Dental care records showed that information related to X-rays was mostly recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. However, there were some examples where this had not been recorded, and this information had not always been identified within the X-ray audits.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic dental care records for each patient. Dental care records contained information about the assessment, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and identified with risk factors such as smoking and diet for each patient.

New patients at the practice completed a medical history form which was scanned into their electronic dental records. Returning patients updated their information on a printed medical history form which was reviewed with the dentist in the treatment room. Any changes were recorded into the patients' dental care records by the dentist. The patients' medical histories included any health conditions, medicines being taken and whether the patient had any allergies.

The dental care records showed that dentists assessed the patients' periodontal tissues (the gums) and soft tissues of the mouth. The dentists used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.

We saw the dentist used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with the dentist showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and lower wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had two waiting rooms for patients, one upstairs and one downstairs. There were posters and leaflets relating to good oral health and hygiene on display.

Children seen at the practice were offered fluoride varnish application and fluoride toothpaste if they were identified as being at risk. A leaflet in the waiting rooms explained the importance of fluoride varnish. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health. Discussions with the dentist showed they had a good knowledge and understanding of 'delivering better oral health' toolkit. Leaflets in the waiting room explained the importance of fluoride and the benefits for patients' teeth.

We saw several examples in patients' dental care records that the dentist had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, the dentist had particularly highlighted the risk of dental disease and oral cancer. The dental care records contained an oral cancer risk assessment. Where appropriate within dental care records we saw the risk assessments for caries (tooth decay) and periodontal disease (gum disease) were also recorded

Staffing

The practice had four dentists (one was a locum dentist); one dental hygienist/ therapist; one qualified dental nurse; two trainee nurses; one receptionist and one practice manager. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

We looked at staff training records for clinical staff to identify that they were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the GDC. The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: radiography (X-rays), medical emergencies, infection control, and safeguarding. However, the CPD records did not show any training in respect of legal and ethical issues for dentists. The practice manager said they would look into this and forward any relevant CPD training certificates to CQC.

Records at the practice showed that all staff had an annual appraisal. This was completed with the practice manager. Organisation's area manager. The provider also reviewed

Are services effective?

(for example, treatment is effective)

and audited dentists' dental records as part of the appraisal process. We also saw evidence of new members of staff having an in-depth induction programme with an identified staff support within the practice.

Working with other services

The practice made referrals to other dental professionals based on risks or if a service was required that was not offered at the practice. We saw the practice referred to other local dental services, orthodontic practices and for minor oral surgery.

The practice did not provide a sedation service. Therefore if a patient required sedation they were referred elsewhere. This was usually through a local community dental practice for NHS patients. If the practice was unable to perform minor oral surgery they referred to the Rego system which handled referrals centrally and allocated them as required. Children or patients with special needs who required more specialist dental care would be referred to the community dental service.

The practice referral system was monitored through the electronic Rego system. This allowed referrals to be tracked and to monitor that referrals had been received.

Referrals for suspected cancer were fast tracked with referrals faxed through to the hospital. A dentist gave an example of how a referral had been made and the patient had had begun treatment for oral cancer at the hospital. The practice also made referrals for NHS orthodontic treatment (where badly positioned teeth are repositioned to give a better appearance and improved function).

Consent to care and treatment

The practice had a consent policy which was dated December 2015. made reference to the Mental Capacity Act 2005 (MCA). The issue of capacity was explored within the policy and this included making best interest decisions as identified in the MCA. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

We saw how consent was recorded in the patients' dental care records. The records showed the dentist had discussed the treatment plan with the patients, which allowed patients to give their informed consent. As most patients received NHS treatment the practice recorded consent on a computerised copy of the FP17 DC form, the standard NHS consent form.

We talked with dental staff about this and identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge. The consent policy made reference to Gillick and explained the circumstances for treating children.

Are services caring?

Our findings

During the inspection we observed staff speaking with patients. We saw that staff were polite, and had a professional approach. We saw that staff spoke with patients with due regard to dignity and respect.

The reception desk was located within the downstairs waiting room. We asked reception staff how patient confidentiality was maintained at reception. Staff said that details of patients' individual treatment were never discussed at the reception desk. In addition if it were necessary to discuss a confidential matter, there were areas of the practice where this could happen such as an unused treatment room.

We saw examples that showed patient confidentiality was maintained at the practice. For example we saw that computer screens could not be overlooked at the reception desk. Patients' dental care records were held securely and password protected.

Involvement in decisions about care and treatment

We received positive feedback from 16 patients about the services provided. This was through CQC comment cards left at the practice prior to the inspection, and by speaking to patients in the practice during the inspection.

The practice offered mostly NHS treatments (95%) and the costs of both NHS and private treatment were clearly displayed in the waiting room.

We spoke with dentists about how patients had their diagnosis and dental treatment discussed with them. The dentists showed us a selection of patient care records to demonstrate how the treatment options were explained and recorded. Patients were given a written copy of the treatment plan.

Where necessary the dentists gave patients information about preventing dental decay and gum disease. In particular the dentists had highlighted the risks associated with smoking and diet, and we saw examples of this recorded in the dental care records. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The patient areas of the practice were located on the ground and first floor of the premises. There was time limited car parking outside the practice, or street parking a short walk away. Alternatively there was car parking in the town centre.

The practice had separate staff and patient areas, to assist with confidentiality and security.

We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. To facilitate this, the practice made a specific appointment slots available for patients who were in pain or alternatively patients could sit and wait to be seen.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist. The appointment book also identified where patients were being seen in an emergency.

Tackling inequity and promoting equality

The practice had an equal opportunities policy and an easy read copy of the Equality Act (2010) and gave staff guidance on treating patients without prejudice or discrimination.

There were four treatment rooms two of which were situated on the ground floor. This allowed patients with restricted mobility easy access for treatment at the practice. The practice was not accessible to patients who used a wheelchair due to stepped entrance and a steep ramp. However, the provider had another practice 150 yards away which was fully accessible for patients who used a wheelchair. The practice had an access statement which made this clear.

The practice had one ground floor toilet for patients to use. This had support bars to assist patients with restricted mobility. However, the room was not large enough to accommodate a patient using a wheelchair.

The practice could accommodate patients with restricted mobility; with access to the ground floor treatment rooms. The practice had a hearing induction loop to assist patients who used a hearing aid. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices.

The practice had access to a recognised company to provide interpreters for patients whose first language was not English.

Access to the service

The practice's opening hours were – Monday to Wednesday: 8:30 am to 6 pm; Thursday: 8:30 am to 5 pm; Friday: 8:30 am to 4 pm. The practice is closed at the weekend.

The practice had a website: www.mydentist.co.uk This allowed patients the opportunity to access the latest information and check opening times or treatment options on-line. Information regarding opening times was also available on the NHS Choices website: www.nhs.uk.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. Alternatively patients could telephone the NHS 111 number.

The practice operated an e mail and text message reminder service for patients who had appointments with the dentist. Patients received an e mail or text message 48 hours before their appointment was due.

Concerns & complaints

The practice had a complaints policy which was on display in the downstairs waiting room. The policy explained how to complain and identified time scales for complaints to be responded to. Other agencies to contact if the complaint was not resolved to the patients satisfaction were identified within the complaint resolution policy.

From information received before the inspection we saw that there had been nine formal complaints received in the 12 months prior to our inspection. The documentation showed the complaints had been handled appropriately and an apology and an explanation had been given to the patient where appropriate.

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Our findings

Governance arrangements

We saw a number of policies and procedures at the practice. We saw that policies had been kept under review and most were identified for review in December 2016.

We spoke with staff who said they understood the structure of the practice and the wider organisation. Staff said if they had any concerns they would raise these with either the practice owner or one of the dentists. We spoke with two members of staff who said they liked working at the practice.

We saw a selection of dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw contained sufficient detail and identified patients' needs, care and treatment.

Leadership, openness and transparency

We saw that full staff meetings were scheduled for once a month throughout the year. The agenda for the full staff meeting covered areas such as: significant events, infection control, and health and safety. We saw that where there were learning points these were shared with staff. The minutes indicated that staff were well informed and supported at the practice.

Discussions with staff showed there was a good understanding of how the practice worked, and knowledge of policies and procedures.

The practice had a duty of candour within the incident reporting procedures. This directed staff to be open and to offer apologies when things had gone wrong. The policy had been produced in July 2016. An example of the policy being put into practice had been when a patient's treatment had not gone as expected. This had left the patient in pain and unhappy with the treatment they had received. The documentation showed that a written apology and explanation had been sent to the patient. Discussions with dentists at the practice showed they had a good understanding of duty of candour.

The practice had a whistleblowing policy which had been amended in September 2016. This identified how staff could raise any concerns they had about colleagues' under-performance, conduct or clinical practice. This was both internally and with identified external agencies. A copy of the policy was available to all staff at the practice.

Learning and improvement

We saw the practice completed a range of audits throughout the year. This was for clinical and non-clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved. Examples of completed audits included: Infection control audits had been completed in September 2014, April 2015 and October 2016. The guidance recommends six monthly audits which had not been achieved. The practice manager who had recently come into post said regular six monthly audits would be completed in future. The most recent audit had produced an action plan and we saw how the action plan was being implemented to achieve improvements. The practice was completing regular audits of radiographs (X-rays). The audits checked the quality of the X-rays and the justification for taking the X-ray and the clinical findings had been recorded in the dental care records. The most recent radiography audits were completed in November 2016. An oral cancer audit had been completed in October 2016 and a prescribing a dental care records audit had been completed in November 2016.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals are required to complete 150 hours over the same period. We saw that key CPD topics such as IRMER (related to X-rays), medical emergencies and safeguarding training had been completed by all relevant staff.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had a NHS Friends and Family Test (FFT) comment box which was located in the waiting room. The FFT is a national programme to allow patients to provide feedback on the services provided. The FFT comment box was being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS

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England. The latest information in the practice showed positive feedback with 100% of patients who responded saying they would recommend the practice to family and friends.

There had been three patient reviews recorded on the NHS Choices website in the year up to this inspection. There had been two reviews posted prior to this.

The practice operated its own satisfaction survey on an on-going basis. Patients who received a text message reminder that their appointment was due receive an invitation to leave feedback which was analysed centrally. Analysis of the latest responses showed the results were positive.

Within the practice there were cards identifying patients could provide feedback about the practice using the QR reader app on their smartphones. This gave patients who had a smartphone the opportunity to leave feedback directly to the provider.